

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12359 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12359

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt 2 - Box 76</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Allen</u> Middle <u>Allen</u> Last		4. DATE OF DEATH <u>Nov.</u> Month <u>5</u> Day <u>1957</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Hand</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Russell Allen, Easton, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>4-91X</u> DUE TO <u>HCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Louis M. Welly</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>WELLY</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/11/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Swyg Town</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Rt. 4, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Doshier, Easton, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>NOV 20 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mrs. M. H. Hovins</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12327

CERTIFICATE OF DEATH

Reg. Dist. No.

12330

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Easton			
d. NAME OF HOSPITAL (If not in hospital, give street address) 223 Port				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Walter First Brooks Middle Brooks Last				4. DATE OF DEATH Month 11 Day 12 Year 57			
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/25/92	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardner		10b. KIND OF BUSINESS OR INDUSTRY Gardner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Brooks				14. MOTHER'S MAIDEN NAME Lucy Potter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) XXX (If yes, give war or dates of service) XXXX		16. SOCIAL SECURITY NO.		17. INFORMANT Ide Brooks, Easton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 14.8 hours 3 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 Sept. , 19 57 , to 31 Oct. , 19 57 , that I last saw the deceased alive on 31 Oct. , 19 57 , and that death occurred at 2 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Shech		M.D. Easton, Md.		ADDRESS (Street, city or town, state) EASTON		DATE SIGNED 11/18/57 Md.	
PHYSICIAN'S NAME (Type) S. KRECH, JR.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/16/57		22c. NAME OF CEMETERY OR CREMATORY Richards Cem.		22d. LOCATION (City, town, or county) (State) Easton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell, Easton, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 20 1957	
				24b. REGISTRAR'S SIGNATURE Mrs. D. H. K...			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		65		1892		BALTIMORE		MD		USA		USA	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
RETIRED		HEART DISEASE		NATURAL		2 WEEKS		11/15/57		BALTIMORE		MD		USA	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. B.

NOV 20 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>3 wks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>1636 Goldsborough St.</u>	
3. NAME OF DECEASED (Type or print) <u>Oliver Kemp Carroll</u>		4. DATE OF DEATH <u>Nov 2 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 13, 1884</u>
9. AGE (In years lost birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired = Phila. policeman</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Roswell Carroll</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Messick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>204-20-0411</u>	
17. INFORMANT <u>Mrs Lizzie Carroll (Wife)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphosarcoma, Retroperitoneal</u> 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , 19 <u>57</u> , to <u>11/2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/2</u> , 19 <u>57</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Easton Md</u> DATE SIGNED <u>11/4/57</u>			
ACTUAL SIGNATURE <u>P E Cox</u> M.D.		PHYSICIAN'S NAME (Type) <u>P E Cox MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/5/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest</u>		22d. LOCATION (City, town, or county) (State) <u>Federalshere Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. G. Brampton</u> ADDRESS <u>El Bow, Federalshere, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>11/5/57</u>	
24b. REGISTRAR'S SIGNATURE <u>N. H. Newlin</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 12

BUREAU V. S.

NOV 12 1957

RECEIVED

12329 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13609
240

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Caroline</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Denton.</i> 05X2-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital.</i>		d. STREET ADDRESS <i>213 South Sixth ST.</i>	
3. NAME OF DECEASED (Type or print) First <i>Nora</i> Middle <i>Baker</i> Last <i>Craft</i>		4. DATE OF DEATH Month <i>November</i> Day <i>28</i> Year <i>1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 4, 1891</i>
9. AGE (In years last birthday) yrs. <i>66</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James H. Baker</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Elizabeth Callison</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mr James H. Baker (father)</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>154X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Pneumonia</i> , 19 <i>1957</i> , to <i>1957</i> , that I last saw the deceased alive on <i>1957</i> , and that death occurred at <i>2:45 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>F.C.H. Schmidt</i>		M.D. <i>2195 Washington St</i> DATE SIGNED <i>30 Nov 57</i>	
PHYSICIAN'S NAME (Type) <i>F.C.H. Schmidt</i>		<i>Easton 16, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec 2, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Denton</i>		22d. LOCATION (City, town, or county) (State) <i>Denton Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Housh</i>		ADDRESS <i>Denton, Md</i>	
24a. REC'D BY REGISTRAR <i>DATE 12/2/57</i>		24b. REGISTRAR'S SIGNATURE <i>W. H. Neekies</i>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION	
7. MARITAL STATUS		8. COLOR		9. EDUCATION		10. RELIGION		11. SOCIAL CLASS		12. DATE OF DEATH	
13. PLACE OF DEATH		14. CAUSE OF DEATH		15. MANNER OF DEATH		16. PERIOD OF ILLNESS		17. TIME OF DEATH		18. SIGNATURE OF PHYSICIAN	
19. SIGNATURE OF REGISTRAR		20. SIGNATURE OF WITNESSES		21. SIGNATURE OF CLERGYMAN		22. SIGNATURE OF FUNERAL HOME		23. SIGNATURE OF BURIAL PLACE		24. SIGNATURE OF CORONER	

BUREAU V. 2

DEC 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12330

CERTIFICATE OF DEATH

12332

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bozman</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clinton</u> Middle <u>H</u> Last <u>Cunningham</u>				4. DATE OF DEATH Month <u>November</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 27, 1894</u>		9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Oil Standard oil</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>George Cunningham</u>			
14. MOTHER'S MAIDEN NAME <u>Mary H. Long</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mrs Virginia C. Dennis</u> Address <u>(Daughter)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>452x</u> DUE TO <u>Retroperitoneal hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ruptured aneurysm of</u> (c) <u>left iliac artery</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.				ADDRESS (Street, city or town, state) <u>219 S Washington St</u> DATE SIGNED <u>Nov 5 1957</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				Easton 16, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Nov. 4, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Laudy Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balbo Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice H. Newnam</u> ADDRESS <u>Easton Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 11/6/57</u>		24b. REGISTRAR'S SIGNATURE <u>M. H. Newnam</u>	

CERTIFICATE OF DEATH

1957

INDEPENDENT STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>		<p>7. PLACE OF DEATH</p>		<p>8. CAUSE OF DEATH</p>		<p>9. MANNER OF DEATH</p>		<p>10. SIGNATURE OF DECEASED</p>		<p>11. SIGNATURE OF WITNESSES</p>		<p>12. SIGNATURE OF PHYSICIAN</p>		<p>13. SIGNATURE OF CORONER</p>		<p>14. SIGNATURE OF JURY</p>		<p>15. SIGNATURE OF JUDGE</p>		<p>16. SIGNATURE OF CLERK</p>		<p>17. SIGNATURE OF REGISTRAR</p>		<p>18. SIGNATURE OF OFFICIAL</p>		<p>19. SIGNATURE OF OFFICIAL</p>		<p>20. SIGNATURE OF OFFICIAL</p>		<p>21. SIGNATURE OF OFFICIAL</p>		<p>22. SIGNATURE OF OFFICIAL</p>		<p>23. SIGNATURE OF OFFICIAL</p>		<p>24. SIGNATURE OF OFFICIAL</p>		<p>25. SIGNATURE OF OFFICIAL</p>		<p>26. SIGNATURE OF OFFICIAL</p>		<p>27. SIGNATURE OF OFFICIAL</p>		<p>28. SIGNATURE OF OFFICIAL</p>		<p>29. SIGNATURE OF OFFICIAL</p>		<p>30. SIGNATURE OF OFFICIAL</p>		<p>31. SIGNATURE OF OFFICIAL</p>		<p>32. SIGNATURE OF OFFICIAL</p>		<p>33. SIGNATURE OF OFFICIAL</p>		<p>34. SIGNATURE OF OFFICIAL</p>		<p>35. SIGNATURE OF OFFICIAL</p>		<p>36. SIGNATURE OF OFFICIAL</p>		<p>37. SIGNATURE OF OFFICIAL</p>		<p>38. SIGNATURE OF OFFICIAL</p>		<p>39. SIGNATURE OF OFFICIAL</p>		<p>40. SIGNATURE OF OFFICIAL</p>		<p>41. SIGNATURE OF OFFICIAL</p>		<p>42. SIGNATURE OF OFFICIAL</p>		<p>43. SIGNATURE OF OFFICIAL</p>		<p>44. SIGNATURE OF OFFICIAL</p>		<p>45. SIGNATURE OF OFFICIAL</p>		<p>46. SIGNATURE OF OFFICIAL</p>		<p>47. SIGNATURE OF OFFICIAL</p>		<p>48. SIGNATURE OF OFFICIAL</p>		<p>49. SIGNATURE OF OFFICIAL</p>		<p>50. SIGNATURE OF OFFICIAL</p>		<p>51. SIGNATURE OF OFFICIAL</p>		<p>52. SIGNATURE OF OFFICIAL</p>		<p>53. SIGNATURE OF OFFICIAL</p>		<p>54. SIGNATURE OF OFFICIAL</p>		<p>55. SIGNATURE OF OFFICIAL</p>		<p>56. SIGNATURE OF OFFICIAL</p>		<p>57. SIGNATURE OF OFFICIAL</p>		<p>58. SIGNATURE OF OFFICIAL</p>		<p>59. SIGNATURE OF OFFICIAL</p>		<p>60. SIGNATURE OF OFFICIAL</p>		<p>61. SIGNATURE OF OFFICIAL</p>		<p>62. SIGNATURE OF OFFICIAL</p>		<p>63. SIGNATURE OF OFFICIAL</p>		<p>64. SIGNATURE OF OFFICIAL</p>		<p>65. SIGNATURE OF OFFICIAL</p>		<p>66. SIGNATURE OF OFFICIAL</p>		<p>67. SIGNATURE OF OFFICIAL</p>		<p>68. SIGNATURE OF OFFICIAL</p>		<p>69. SIGNATURE OF OFFICIAL</p>		<p>70. SIGNATURE OF OFFICIAL</p>		<p>71. SIGNATURE OF OFFICIAL</p>		<p>72. SIGNATURE OF OFFICIAL</p>		<p>73. SIGNATURE OF OFFICIAL</p>		<p>74. SIGNATURE OF OFFICIAL</p>		<p>75. SIGNATURE OF OFFICIAL</p>		<p>76. SIGNATURE OF OFFICIAL</p>		<p>77. SIGNATURE OF OFFICIAL</p>		<p>78. SIGNATURE OF OFFICIAL</p>		<p>79. SIGNATURE OF OFFICIAL</p>		<p>80. SIGNATURE OF OFFICIAL</p>		<p>81. SIGNATURE OF OFFICIAL</p>		<p>82. SIGNATURE OF OFFICIAL</p>		<p>83. SIGNATURE OF OFFICIAL</p>		<p>84. SIGNATURE OF OFFICIAL</p>		<p>85. SIGNATURE OF OFFICIAL</p>		<p>86. SIGNATURE OF OFFICIAL</p>		<p>87. SIGNATURE OF OFFICIAL</p>		<p>88. SIGNATURE OF OFFICIAL</p>		<p>89. SIGNATURE OF OFFICIAL</p>		<p>90. SIGNATURE OF OFFICIAL</p>		<p>91. SIGNATURE OF OFFICIAL</p>		<p>92. SIGNATURE OF OFFICIAL</p>		<p>93. SIGNATURE OF OFFICIAL</p>		<p>94. SIGNATURE OF OFFICIAL</p>		<p>95. SIGNATURE OF OFFICIAL</p>		<p>96. SIGNATURE OF OFFICIAL</p>		<p>97. SIGNATURE OF OFFICIAL</p>		<p>98. SIGNATURE OF OFFICIAL</p>		<p>99. SIGNATURE OF OFFICIAL</p>		<p>100. SIGNATURE OF OFFICIAL</p>	
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BUREAU V. S.

NOV 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.
80 Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12331

CERTIFICATE OF DEATH

12333

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIDGELY</u> 05x1.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL HOSPITAL</u>		d. STREET ADDRESS <u>-</u>	
3. NAME OF DECEASED (Type or print) First <u>ALBERT</u> Middle <u>-</u> Last <u>DEAN</u>		4. DATE OF DEATH Month <u>NOV.</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 27, 1880</u> 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>CHARLES H. DEAN</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE PAYNE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>MR H. H. Dean (brother)</u> Address <u>-</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>15 weeks pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1952</u> , 19 <u>52</u> , to <u>11/15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/14</u> , 19 <u>57</u> , and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>P. E. Cox</u> M.D.			
PHYSICIAN'S NAME (Type) <u>P. E. Cox</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/18/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>	22d. LOCATION (City, town, or county) (State) <u>Greensboro Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulain</u> ADDRESS <u>Greensboro Md.</u>		24a. REC'D BY REGISTRAR DATE <u>11/21/57</u>	
		24b. REGISTRAR'S SIGNATURE <u>N. H. Neuman</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH	
9. OCCUPATION		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. MEDICAL HISTORY		13. PREVIOUS ILLNESS		14. PREVIOUS SURGERY		15. PREVIOUS TRAUMA		16. PREVIOUS DRUGS	
17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF REGISTRAR		19. SIGNATURE OF WITNESS		20. SIGNATURE OF DECEASED		21. SIGNATURE OF NEXT OF KIN		22. SIGNATURE OF CLERGYMAN		23. SIGNATURE OF JUDGE		24. SIGNATURE OF JURY	

BUREAU V. 2

NOV 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12332 CERTIFICATE OF DEATH

12334
Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William E</u> Middle <u>Dobson</u> Last <u>Dobson</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 3, 1907</u>	9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
13. FATHER'S NAME <u>George Dobson</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Pinkett</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>334X</u>				17. INFORMANT <u>Luda Dobson</u> Address <u>219 S. Washington St. Easton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Edema</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malignant Hypertension</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>11</u> a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, at _____ M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>219 S. Washington St. Easton, Md.</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				DATE SIGNED <u>Nov 57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/11/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Richards</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Oschell</u> ADDRESS <u>Easton, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>11/11/57</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Neer</u>	

CERTIFICATE OF DEATH

1957

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. OCCUPATION		6. MARITAL STATUS	
7. PLACE OF BIRTH		8. DATE OF BIRTH		9. DATE OF DEATH	
10. TIME OF DEATH		11. CAUSE OF DEATH		12. MANNER OF DEATH	
13. PLACE OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF CORONER	
19. SIGNATURE OF JUDGE		20. SIGNATURE OF CLERK		21. SIGNATURE OF NOTARY	
22. SIGNATURE OF CHURCH		23. SIGNATURE OF SCHOOL		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
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RECEIVED
NOV 15 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12333 CERTIFICATE OF DEATH

13610
Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>05X02</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial</u>				d. STREET ADDRESS <u>Denton</u>			
3. NAME OF DECEASED (Type or print) First <u>Archie</u> Middle <u>Downes</u> Last <u>Downes</u>				4. DATE OF DEATH Month <u>11</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 13 1887</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Walter Downes</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Scott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Archie F. Downes, Jr. Son - Dover Del</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>420.1</u> DUE TO <u>Ventricular aneurysm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarct</u> (c) <u>Myocardial infarct</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT-RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Renal cell carcinoma, right</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Pathologist</u> , 19 <u> </u> , to <u>8:30 A.M.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/2/57</u> , and that death occurred at <u>8:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>219 S. West 117th St</u>			
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>				DATE SIGNED <u>28 Nov 57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 2 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		22d. LOCATION (City, town, or county) (State) <u>Denton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. V. Moorsen</u>				ADDRESS <u>H.B. Denton</u>		24a. REC'D BY REGISTRAR <u>N. H. Nevins</u>	
				24b. REGISTRAR'S SIGNATURE <u>N. H. Nevins</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
MARITAL STATUS		EDUCATION		OCCUPATION		RELIGION		MANNER OF DEATH		CAUSE OF DEATH	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		TEMPERATURE		PULSE		RESPIRATION	
SIGNS AND SYMPTOMS		TREATMENT		HISTORY		PATHOLOGICAL FINDINGS		LABORATORY TESTS		POST-MORTEM FINDINGS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF FATHER		SIGNATURE OF MOTHER	

BUREAU V. S.

DEC 10 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G222 11-20-57 et

12334

CERTIFICATE OF DEATH

12335

Reg. Dist. No. 270

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>16 da.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u> 05x0.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>05x0.2</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Downing</u> Last <u>Downing</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1911</u>	9. AGE (In years last birthday) <u>46</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mac Downing</u>				14. MOTHER'S MAIDEN NAME <u>Ella</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Willie May Downing (wife)</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lung abscess</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes mellitus</u> DUE TO (c) <u>Insulin Shock</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10/20/57</u> <u>?</u> <u>10/17/57</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/17</u> , 19 <u>57</u> , to <u>11/2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/2</u> , 19 <u>57</u> , and that death occurred at <u>11:30 a.m.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>P E Cox</u> M.D.				ADDRESS (Street, city or town, state) <u>Easton Md</u> DATE SIGNED <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/8/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Norfolk Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Orshell</u> ADDRESS <u>Easton, Md.</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>11/6/57</u>		24b. REGISTRAR'S SIGNATURE <u>N. St. Neelce</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12335 CERTIFICATE OF DEATH

Reg. Dist. No. 12336 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>2 hr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>xo Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>1 R7D #3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>H.</u> Last <u>Dudley</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 1, 1881</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>6</u>		IF UNDER 24 HRS. Hours <u>7</u> Min. <u>6</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas A. Dudley</u>				14. MOTHER'S MAIDEN NAME <u>Mary L. Rathell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Miss Mary L. Dudley</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO <u>Cirrhosis of the liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1957</u> Hour <u>11</u> a. m. <u>30</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>	
21. I certify that I attended the deceased from <u>11:30 AM</u> , 19 <u>57</u> , to <u>11:30 AM</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 12, 1957</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.				ADDRESS (Street, city or town, state) <u>219 S. Washington St. Easton, Md.</u> DATE SIGNED <u>14 Nov 57</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				ADDRESS <u>Easton 16, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 15, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		22d. LOCATION (City, town, or county) <u>Easton</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ellis B. Clark</u> ADDRESS <u>Easton Md</u>				24a. REC'D BY REGISTRAR <u>DATE 11/15/57</u>		24b. REGISTRAR'S SIGNATURE <u>M. H. Neenan</u>	

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MD.		DATE OF DEATH _____	
NAME OF DECEASED _____		SEX _____	
AGE _____		RACE _____	
PLACE OF BIRTH _____		PLACE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
DATE OF DEATH _____		TIME OF DEATH _____	
PLACE OF DEATH _____		NAME OF PHYSICIAN _____	
NAME OF FUNERAL HOME _____		NAME OF BURIAL PLACE _____	
NAME OF NEXT OF KIN _____		NAME OF WITNESS _____	
NAME OF REGISTRAR _____		NAME OF CLERK _____	

BUREAU V. S.

NOV 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12360

CERTIFICATE OF DEATH

13612

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Walter Elliott				4. DATE OF DEATH Month 11 Day 30 Year 1957			
5. SEX Male		6. COLOR OR RACE Col		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/16	
9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR Months 11 Days 30 Hours 19 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill		10b. KIND OF BUSINESS OR INDUSTRY Lumberman	
11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unkown		14. MOTHER'S MAIDEN NAME Mary Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 6		16. SOCIAL SECURITY NO. 251-05-4404		17. INFORMANT Violet King		Address Trappe Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 acute coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chronic coronary insufficiency DUE TO (c) a year						INTERVAL BETWEEN ONSET AND DEATH year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from my 30 , 19 57 , to my 30 , 19 57 , that I last saw the deceased alive on 19 , and that death occurred at 4p M, from the causes and on the date stated above.							
ACTUAL SIGNATURE E Paul Knotts M.D.				ADDRESS (Street, city or town, state) Denton Md DATE SIGNED 12/3/57			
PHYSICIAN'S NAME (Type) E Paul Knotts				Menton Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/4/57		22c. NAME OF CEMETERY OR CREMATORY New Town Cem.		22d. LOCATION (City, town, or county) (State) Cordova Md	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell				ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DEC 11 1957	
				24b. REGISTRAR'S SIGNATURE Mrs. D. J. Kearney			

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G224 1-3-58 et

CERTIFICATE OF DEATH

12361

12337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Tabot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 114				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Williamm Henry Freeman				4. DATE OF DEATH Month 11 Day 23 Year 19 57			
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/15/1897	9. AGE (In years last birthday) yrs. 60	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffer			10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Henry Freeman				14. MOTHER'S MAIDEN NAME Agnes Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 378-18-3233		17. INFORMANT Agnes Mills		Address Easton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Asthma 434.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Hayward T. Webb				ADDRESS (Street, city or town, state) 633 Pleasant St. Easton, Md.		DATE SIGNED 11/26/57	
PHYSICIAN'S NAME (Type) Hayward T. Webb							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/26/57		22c. NAME OF CEMETERY OR CREMATORY Trappe cem,		22d. LOCATION (City, town, or county) (State) Trappe md.	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell				ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DEC 3 1957	
				24b. REGISTRAR'S SIGNATURE Mrs. T. J. Turner			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

DEC 3 1957

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Form 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.
The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12336 CERTIFICATE OF DEATH

Reg. Dist. No.

12338
290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John C. Gale</u>		4. DATE OF DEATH <u>November 10 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 28 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		9. AGE (In years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John K.C. Gale</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Baker</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. William E. Reddie (Nephew)</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coccarino Head of Paroxysms</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/1/57</u> , 19 <u>57</u> , to <u>11/13/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/13/57</u> , and that death occurred at <u>1:55 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E.C.H. Schmitt</u> M.D.		ADDRESS (Street, city or town, state) <u>2195 W. 4th St. Easton, Md.</u> DATE SIGNED <u>11/16/57</u>	
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmitt</u>		<u>Easton 16, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>11/12/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Easton, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Beaumont</u> ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR <u>11/13/57</u> 24b. REGISTRAR'S SIGNATURE <u>N.A. Newins</u>	

CERTIFICATE OF DEATH

2-25-54 (Rev. 1-1-54)

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER		REMARKS	
OCCUPATION		EDUCATION		RELIGION		RACE		COLOR		HAIR		EYES		SKIN	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF FUNERAL HOME		SIGNATURE OF BURIAL PLACE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		REMARKS		REMARKS	

BUREAU V. S.

NOV 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
this 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.
Register prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12339

12337 CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>3 da.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>10 Be Neve</u>	
3. NAME OF DECEASED (Type or print) First <u>Acubrey</u> Middle <u>Goldsborough</u> Last <u>Goldsborough</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5, 1891</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Goldsborough</u>		14. MOTHER'S MAIDEN NAME <u>Harriet H Adams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Pauline Goldsborough, wife - Belbourn</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X Lobular pneumonia</u> DUE TO (b) <u>Hypertensive cerebral-vascular disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>219 S. Washington St. Easton, Md.</u> DATE SIGNED <u>2 Nov. 57</u>	
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.		21b. REGISTRAR'S SIGNATURE <u>N. H. Newkirk</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		21c. REGISTRAR'S NAME (Type) <u>N. H. Newkirk</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-6-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Ashwell</u> ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>11/6/57</u>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12338

CERTIFICATE OF DEATH

13614
990

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>121 S. Higgin St.</u>				d. STREET ADDRESS <u>121 S. Higgin St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Hester</u> Last <u>Griffin</u>				4. DATE OF DEATH Month <u>11</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/14/69</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>14</u> Days <u>19</u> Hours <u>57</u>		IF UNDER 24 HRS. Months <u>14</u> Days <u>19</u> Hours <u>57</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Emory</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Clayton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>XX</u>				16. SOCIAL SECURITY NO. <u>XX</u>			
17. INFORMANT <u>Mrs Ada Eggerson, Easton, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-Pneumonia</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11/13/57</u> to <u>11/14/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/13/57</u> , and that death occurred at <u>5 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Easton Md</u> DATE SIGNED _____							
ACTUAL SIGNATURE <u>P. F. Cox</u>				M.D. <u>Easton Md</u>			
PHYSICIAN'S NAME (Type) <u>P. F. Cox</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Chapel cem</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, R2, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dashiell, Easton, Md.</u>				24. REC'D BY REGISTRAR DATE <u>DEC 12 1957</u>			
24b. REGISTRAR'S SIGNATURE <u>Mrs. P. L. Henry</u>							

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
Mary Hester Griffin		12/21/68	
Sex		Age	
Female	Col	38	
Place of Birth		Date of Birth	
Maryland		7/14/30	
Cause of Death		Place of Death	
Domestic		Wardens G/9xton	
Occupation		M.A.	
X X		Mrs Ada Edgerton, Easton, Md.	

BUREAU V. 2

DEC 12 1967

RECEIVED

11/19/67 New Chapel com Easton 23, Md.
12/21/68 Easton, Md.

12339

CERTIFICATE OF DEATH

12340

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>4 1/2 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>Sanding Neck, Trappe x0</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Flora</u> Middle <u>Harrison</u> Last <u>Harrison</u>			4. DATE OF DEATH Month <u>11</u> Day <u>12</u> Year <u>1957</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 20, 1886</u>		9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>12</u>	IF UNDER 24 HRS. Hours <u>12</u> Min. <u>57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas J. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Sallie Calhoun</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mr John Harrison (husb)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>apoplexy</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>HCVD</u> DUE TO (c) <u>?</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/11/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/11/57</u> , 19 <u>57</u> , and that death occurred at <u>12:50 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Easton Md</u> DATE SIGNED <u>11/15/57</u>							
ACTUAL SIGNATURE <u>P.E. Cox</u>		M.D. <u>Easton Md</u>					
PHYSICIAN'S NAME (Type) <u>P.E. Cox</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Nov. 15, 57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Newberry</u>				24a. REC'D BY REGISTRAR DATE <u>11/15/57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Newberry</u>	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12362

CERTIFICATE OF DEATH

12341

Reg. Dist. No.

290

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton, Rt. 1				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last James A. Jackson				4. DATE OF DEATH Month Day Year 11 21 1957			
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 1, 1881	9. AGE (In years last birthday) yrs. 76	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman				10b. KIND OF BUSINESS OR INDUSTRY Oysters		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John T. Jackson				14. MOTHER'S MAIDEN NAME Lucille Jackson Philadelphia, Pa.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Lucille Jackson				Address Philadelphia, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cochecia - severe 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) adenocarcinoma sigmoid DUE TO (c) widespread metastases							INTERVAL BETWEEN ONSET AND DEATH 4 mos 19 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 4-3 , 1956 , to 11-21 , 1957 , that I last saw the deceased alive on 11-21 , 1957 , and that death occurred at 2:30 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James M. Dashiell				ADDRESS (Street, city or town, state) Easton, Md.			
PHYSICIAN'S NAME (Type) James M. Dashiell				DATE SIGNED 11-22-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-26-57		22c. NAME OF CEMETERY OR CREMATORY Unionville Cemetery		22d. LOCATION (City, town, or county) (State) Easton, RT1. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell				ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DATE DEC 3 1957	
				24b. REGISTRAR'S SIGNATURE Mrs. N. J. Thomas			

CERTIFICATE OF DEATH

<p>NAME OF DECEASED <i>Lucille Jackson</i></p>		<p>DATE OF DEATH <i>Dec 3 1957</i></p>	
<p>AGE <i>45</i></p>		<p>SEX <i>Female</i></p>	
<p>RACE <i>White</i></p>		<p>EDUCATION <i>High School</i></p>	
<p>BIRTH DATE <i>Aug 15 1912</i></p>		<p>BIRTH PLACE <i>St. Louis, Mo.</i></p>	
<p>DECEASED'S RESIDENCE <i>1234 N. Main St., Baltimore, Md.</i></p>		<p>DECEASED'S OCCUPATION <i>Housewife</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>IMMEDIATE CAUSE OF DEATH <i>Myocardial Infarction</i></p>	
<p>DATE OF BURIAL <i>Dec 5 1957</i></p>		<p>PLACE OF BURIAL <i>St. Mary's Cemetery, Baltimore, Md.</i></p>	
<p>SIGNATURE OF PHYSICIAN <i>[Signature]</i></p>		<p>SIGNATURE OF REGISTRAR <i>[Signature]</i></p>	

BUREAU V. S.

DEC 3 1957

RECEIVED

12363

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>203 talbot st.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>L.</u> Last <u>Jackson</u>				4. DATE OF DEATH Month <u>11</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/27/84</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ebene Warner</u> Address <u>St. Michaels, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <u>Coronary Artery Heart Dis</u> <u>Hypertensive Cardiovascular Dis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u> <u>1 1/2 years</u> <u>10-15 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May</u> , 19 <u>56</u> , to <u>11/11/1957</u> , that I last saw the deceased alive on <u>11/11/1957</u> , and that death occurred at <u>11:50</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Box 487, St. Michaels, Md</u>				DATE SIGNED <u>11-12-57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/13/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chelabone, Am.</u>		22d. LOCATION (City, town, or county) (State) <u>Chelabone Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Easton, Md</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 20 '57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Occupation		Manner of Death		Signature of Physician	
Signature of Registrar		Signature of Coroner		Signature of Medical Examiner	
Date of Burial		Place of Burial		Signature of Minister	
Date of Inquest		Place of Inquest		Signature of Jury	
Date of Report		Place of Report		Signature of Health Officer	
Date of Certificate		Place of Certificate		Signature of Registrar	

BUREAU V. S.

NOV 20 1957

RECEIVED

12364

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TILGHMAN</u>				c. LENGTH OF STAY IN 1b <u>40 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Tilghman - Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —				d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MONNIE</u> Middle <u>T</u> Last <u>JENKINS</u>				4. DATE OF DEATH Month <u>NOV.</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 29, 1907</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Oyster</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>ERNEST A. JENKINS</u>				14. MOTHER'S MAIDEN NAME <u>ROSA DIGGS EVANS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>217-20-3184</u>		17. INFORMANT Address <u>Mrs. PAULINE JENKINS - Tilghman, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>atherosclerosis</u> DUE TO (c) <u>congenital valvular heart disease</u> <u>regional valvular</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <u>20 minutes</u> <u>10 yrs</u> <u>49 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>—</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u>				20g. (County) <u>—</u>		20h. (State) <u>—</u>	
21. I certify that I attended the deceased from <u>1924</u> to <u>Nov 2</u> , 1957, that I last saw the deceased alive on <u>Oct 20</u> , 1957, and that death occurred at <u>3A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Tilghman Md</u> DATE SIGNED <u>Nov 3, 1957</u>							
ACTUAL SIGNATURE <u>GUY M REESER</u> M.D.				PHYSICIAN'S NAME (Type) <u>GUY M REESER Sr MD</u> <u>TILGHMAN Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Tilghman Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Tilghman Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Reeds Moore</u>				ADDRESS <u>Tilghman Md</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 5 '57</u>	
24b. REGISTRAR'S SIGNATURE <u>Reeds Moore</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

TO REGISTRAR: The law requires that the death certificate be executed within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Race		5. Date of death		6. Time of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.
Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12344

12340

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>30 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>Centre ville 17x2.2</u> ✓			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>A</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>November</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 20, 1893</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Power Plant Operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John T. Jones</u>				14. MOTHER'S MAIDEN NAME <u>ELLA Austin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NONE</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>212-03-1957</u>			
17. INFORMANT <u>Mrs. Elizabeth Jones (wife)</u>				Address <u>Centerville, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>199.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>8-2-1954</u> 19____, to <u>11-20-</u> 19 <u>57</u> , that I last saw the deceased alive on <u>11/20/57</u> 19____, and that death occurred at <u>6:35 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm. D. Noble</u> M.D.				ADDRESS (Street, city or town, state) <u>Easton, Md</u>			
DATE SIGNED <u>11/22/57</u>							
PHYSICIAN'S NAME (Type) <u>WM. D. NOBLE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-23-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Church Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Church Hill, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Smith & Sons, Baltimore, Md.</u>				ADDRESS <u>Centerville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>11/23/57</u>	
24b. REGISTRAR'S SIGNATURE <u>N. A. Neeress</u>							

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

RECEIVED

BUREAU V. S.

12365

CERTIFICATE OF DEATH

12345

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Talbot		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND		b. COUNTY Washington, D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels		c. LENGTH OF STAY IN Ib		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rio Vista Nursing Home		d. STREET ADDRESS 4414 16th St. N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Shriver		First W.		Middle King	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 8/8/83		9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Leather Worker		10b. KIND OF BUSINESS OR INDUSTRY Naval Air Factory		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Rowden E. Midgett	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cachexia - generalized - severe 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) carcinoma - Rt. lung & DUE TO (c) generalized metastases		INTERVAL BETWEEN ONSET AND DEATH 6 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) myocardial failure		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 2-9 , 19 56 , to 11-19 , 19 57 , that I last saw the deceased alive on 11-19 , 19 57 , and that death occurred at 5:40 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) St. Michaels Md		DATE SIGNED 11-19-57	
ACTUAL SIGNATURE Raymond R. Reiser		M.D. St. Michaels Md			
PHYSICIAN'S NAME (Type) Raymond R. Reiser					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11/22/57		22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	
22d. LOCATION (City, town, or county) Washington, D.C.					
23. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall		ADDRESS St. Michaels		24a. REG'D. BY REGISTRAR 11-19-57	
24b. REGISTRAR'S SIGNATURE Ch. H. Leach					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NOV 22 1957

BUREAU V. S.

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with information regarding the burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12346

12341

CERTIFICATE OF DEATH

Reg. Dist. No.

290

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton Md				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hosp. - Easton Md.				d. STREET ADDRESS 1138 Hamburg St			
3. NAME OF DECEASED (Type or print) First Charles Middle E. Last Lambdin				4. DATE OF DEATH Month 11 Day 1 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 11, 1886	
9. AGE (In years last birthday) yrs. 71		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Mr. Jacob Lambdin		14. MOTHER'S MAIDEN NAME Mary Haddaway		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Pearl Lambdin - daughter in law		Address Royal Oak, Md		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage - throat 148X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) adenocarcinoma - Rt throat - DUE TO (c) old ulcerative	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 10-30-57 , to 11-1-57 , that I last saw the deceased alive on 11-1-57 , and that death occurred at 9:57 AM , from the causes and on the date stated above.	
ACTUAL SIGNATURE Thos M. Recker		M.D. St Michael Md		ADDRESS (Street, city or town, state) 11-1-57		DATE SIGNED	
PHYSICIAN'S NAME (Type) Thos M. Recker		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-4-57		22c. NAME OF CEMETERY OR CREMATORY Tilghman Methodist	
22d. LOCATION (City, town, or county) (State) Tilghman, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE J. Fred Moore Tilghman Md		ADDRESS 11-4-57		24a. REC'D BY REGISTRAR DATE 11/4/57	
24b. REGISTRAR'S SIGNATURE N.H. Newell							

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John H. Smith</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>	
DATE OF DEATH <i>Nov 11 1957</i>		TIME OF DEATH <i>10:30 AM</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>	
CAUSE OF DEATH <i>Myocardial Infarction</i>		MANNER OF DEATH <i>Natural</i>		OCCUPATION <i>Engineer</i>		EDUCATION <i>High School</i>	
DATE OF BIRTH <i>Oct 15 1912</i>		PLACE OF BIRTH <i>St. Louis, Mo.</i>		MARRIAGE <i>Married</i>		SPOUSE'S NAME <i>John H. Smith</i>	
DATE OF MARRIAGE <i>May 10 1935</i>		PLACE OF MARRIAGE <i>Baltimore, Md.</i>		SPOUSE'S AGE <i>38</i>		SPOUSE'S SEX <i>Female</i>	
DATE OF DEATH <i>Nov 11 1957</i>		TIME OF DEATH <i>10:30 AM</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>	
CAUSE OF DEATH <i>Myocardial Infarction</i>		MANNER OF DEATH <i>Natural</i>		OCCUPATION <i>Engineer</i>		EDUCATION <i>High School</i>	
DATE OF BIRTH <i>Oct 15 1912</i>		PLACE OF BIRTH <i>St. Louis, Mo.</i>		MARRIAGE <i>Married</i>		SPOUSE'S NAME <i>John H. Smith</i>	
DATE OF MARRIAGE <i>May 10 1935</i>		PLACE OF MARRIAGE <i>Baltimore, Md.</i>		SPOUSE'S AGE <i>38</i>		SPOUSE'S SEX <i>Female</i>	

BUREAU V. S.

NOV 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12342

CERTIFICATE OF DEATH

12342
Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg 05x12			
d. NAME OF HOSPITAL (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS Federalsburg 05x12			
3. NAME OF DECEASED (Type or print) First Baby Middle Gerri Last Ling				4. DATE OF DEATH Month Nov Day 2 Year 1957			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 2, 1957	
9. AGE (In years last birthday) yrs. 2		10. IF UNDER 1 YEAR Months 2 Days 4		11. IF UNDER 24 HRS. Hours 2 Min. 4		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn				10b. KIND OF BUSINESS OR INDUSTRY MD			
11. BIRTHPLACE (State or foreign country) MD				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George Stanley Ling				14. MOTHER'S MAIDEN NAME June Anne Gray			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. MD			
17. INFORMANT M Menge Perry				Address —			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773.5 Prematurity DUE TO (b) Respiratory Failure Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) —							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 11-2 , 19 57 , to 11-2 , 19 57 , that I last saw the deceased alive on 11-2 , 19 57 , and that death occurred at 12:30 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE John E. Baybutt				ADDRESS (Street, city or town, state) 205 Earle Ave Easton MD 119157			
PHYSICIAN'S NAME (Type) John E. Baybutt				DATE SIGNED 11/9/57			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 11/4/57		22c. NAME OF CEMETERY OR CREMATORY Bloomery		22d. LOCATION (City, town, or county) (State) Federalsburg MD	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Hampton				ADDRESS 205 Earle Ave Easton, Maryland			
24a. REC'D BY REGISTRAR 11/7/57				24b. REGISTRAR'S SIGNATURE N. H. Meever			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12343

CERTIFICATE OF DEATH

12348

Reg. Dist. No. 290

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>1 hr 3 min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>BOY</u> Middle <u>LING</u> Last <u>#2</u>		4. DATE OF DEATH Month <u>11</u> Day <u>2</u> Year <u>1957</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/2/57</u>		9. AGE (In years last birthday) <u>18</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>newborn</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>				13. FATHER'S NAME <u>GEORGE STANLEY LING</u>			
14. MOTHER'S MAIDEN NAME <u>JUNE ANNE GRAY</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mr George Ling (father)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity (wgt #125)</u> DUE TO (b) <u>Twin</u> DUE TO (c) <u>Interval between onset and death 1 hr</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>11-2</u> , 19 <u>57</u> , to <u>11-2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-2</u> , 19 <u>57</u> , and that death occurred at <u>11:54</u> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John E. Baybutt</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>205 E. 1st Ave Easton Md 11-2-57</u>			
PHYSICIAN'S NAME (Type) <u>John E. Baybutt</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bloomery</u>		22d. LOCATION (City, town, or county) (State) <u>near Federalburg Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Hampton</u> ADDRESS <u>205 E. 1st Ave, Federalburg, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>11/4/57</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Perkins</u>	

2280182XVO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

NOV 12 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 290

12344

1. PLACE OF DEATH a. COUNTY <u>Talbot</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>26 da.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Vienna 29x0.2</u>	
3. NAME OF DECEASED (Type or print) <u>Dora</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>14</u> Year <u>1957</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 7 1891</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Utah</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mr. Charles Ellis</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Gordy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Miss Pauline May</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO Candilans, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> o. <u> </u> p. <u> </u> Month, <u> </u> Day, <u> </u> Year <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>1941</u> , 19 <u> </u> , to <u>11/14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/14</u> , 19 <u>57</u> , and that death occurred at <u>8:30</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>Wm. D. Noble</u>		M.D. <u> </u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM D. NOBLE</u>		<u>EASTON, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/14/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Don memo Book</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Mass</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Capt. Bureau Service</u>		ADDRESS <u> </u>	
24a. REC'D BY REGISTRAR DATE <u>11/15/57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Neekin</u>	

BUREAU V. S.

NOV 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12350

12345 CERTIFICATE OF DEATH

Reg. Dist. No.

290

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON				c. LENGTH OF STAY IN 1b 3 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MAUDE Middle A. Last MERRIMAN				4. DATE OF DEATH Month NOV Day 26 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 28 1874	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) EAST ORANGE, N.J.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RICHARD D. JACKSON				14. MOTHER'S MAIDEN NAME JESSIE DUNCAN ELLIOTT HIXON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Harry M. Merriman Jr		Address Easton Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Decompensation 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Auricular Fibrillation DUE TO (c) Arterio sclerotic Heart Disease						INTERVAL BETWEEN ONSET AND DEATH 3da 2 yrs - over 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arterio sclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 6-28 , 19 54 , to 11-26 , 19 57 , that I last saw the deceased alive on 11-26 , 19 57 , and that death occurred at 7-PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William L. Winters				ADDRESS (Street, city or town, state) 210 E. DOVER EASTON MD			
PHYSICIAN'S NAME (Type) WILLIAM L. WINTERS				DATE SIGNED 11/27/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF NOV, 29, 1957		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Fort Myer Va	
23. FUNERAL DIRECTOR'S SIGNATURE L. Hampton Harrison				ADDRESS St. Michaels Md		24a. REC'D BY REGISTRAR DEC 2 1957	
				24b. REGISTRAR'S SIGNATURE Mrs. D. H. Harrison			

BUREAU V. S.

DEC 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12346

CERTIFICATE OF DEATH

Reg. Dist. No.

12351
290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woolford</u> 09X0.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Herbert</u> Middle <u>D.</u> Last <u>Mills</u>				4. DATE OF DEATH Month <u>11</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 16, 1895</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John R. Mills</u>				14. MOTHER'S MAIDEN NAME <u>Katie Hall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Marie Hanes (daughter)</u> Address <u>Real St. Exeter, Cambridge</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Herpes zoster virus</u> 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rupture of spleen</u> DUE TO (c) <u>Lymphosarcoma</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>219 S. Washington St. 25X0.57</u> E.C.H. Schmidt M.D. <u>Easton 16, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
<u>Buried</u>				<u>11/28/57</u>		<u>Easton Memorial Park</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR	
<u>W. H. Neeris</u>				<u>Cambridge, Md.</u>		DATE <u>11/28/57</u>	
				24b. REGISTRAR'S SIGNATURE			

BUREAU V. S.

NOV 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G223 11-27-57 et

12347

CERTIFICATE OF DEATH

12353
Reg. Dist. No. 240

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Racelia</u> Middle <u>Pieman</u> Last <u>Pieman</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 28, 1874</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Henry Pieman</u>			
14. MOTHER'S MAIDEN NAME <u>Emma Debaugh</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Mrs. Herbert J. Anshen</u> Address <u>Easton Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Intestinal Obstruction</u> <u>5610</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Strangulated of sigmoid tumor</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.				ADDRESS (Street, city or town, state) <u>219 S W 25th Street St. 100</u> DATE SIGNED <u>11/11/57</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				ADDRESS <u>Easton 16, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 11, 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		22d. LOCATION (City, town, or county) <u>Baltimore</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Newlin</u> ADDRESS <u>Easton</u>				24a. REC'D BY REGISTRAR DATE <u>11/11/57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Newlin</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

NOV 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12348

CERTIFICATE OF DEATH

Reg. Dist. No. 290

12354

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>6da 7 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>E</u> Last <u>Seymour</u>				4. DATE OF DEATH Month <u>11</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-9-1887</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bridge Tender</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George A. Seymour</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Freeman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>McAnnick, Seymour (wife)</u> Address <u>Newcomb, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>anemia</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>arteriolar nephrosclerosis</u> DUE TO <u>2 yrs</u> (b) <u>arteriolar nephrosclerosis</u> DUE TO <u>2 yrs</u> (c) <u>arteriolar nephrosclerosis</u> DUE TO <u>2 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>anemia, Diabetes Mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Dec 1957</u> , to <u>11-13-57</u> , that I last saw the deceased alive on <u>11-13-57</u> , and that death occurred at <u>3:05 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Guy M. Reeser Jr</u>				DATE SIGNED <u>11-13-57</u>			
PHYSICIAN'S NAME (Type) <u>Guy M. Reeser Jr</u>				M.D. <u>St. Michaels md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-15-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Springhill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robertson Harrison, St. Michaels</u>				24a. REC'D BY REGISTRAR DATE <u>11/15/57</u>		24b. REGISTRAR'S SIGNATURE <u>N.H. Reeser</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12349

CERTIFICATE OF DEATH

12355

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Long Woods</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Sharp</u> Last <u>Sharp</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/1/59</u>		9. AGE (In years last birthday) <u>68</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William M. Sharp</u>				14. MOTHER'S MAIDEN NAME <u>Emma Tapman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Miss Abbie Sharp (Sister)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage of Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <u>Easton</u>		(County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>				DATE SIGNED <u>2195 Washington St 19 Nov 57</u>			
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>				ADDRESS (Street, city or town, State) <u>Easton 16, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HILLSBORO, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hampton Goss</u>				ADDRESS <u>Easton, MD.</u>		24a. REC'D BY REGISTRAR <u>DATE 11/21/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>N.H. Newen</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		DATE OF DEATH _____	
TIME OF DEATH _____		PLACE OF DEATH _____	
CAUSE OF DEATH _____		MANNER OF DEATH <input type="checkbox"/> NATURAL <input type="checkbox"/> ACCIDENTAL <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE	
MEDICAL HISTORY _____		OCCASION OF DEATH _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF REGISTRAR _____	
SIGNATURE OF WITNESS _____		SIGNATURE OF DECEASED _____	

BUREAU V. 1

NOV 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.
 Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12350

CERTIFICATE OF DEATH

13637

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton, md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>575 August Street</u>			
3. NAME OF DECEASED (Type or print) <u>Lillian Belle Skinner</u>				4. DATE OF DEATH Month <u>11</u> Day <u>27</u> Year <u>19 57</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-1-1886</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GREENBERRY MARSHALL</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE HANCOCK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>BERNARD S. SKINNER</u>		Address <u>AUGUST ST. EASTON, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction -</u> <u>420.1</u> DUE TO <u>recent & old</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>11:30</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>2195 Washington St. Easton, Md.</u> DATE SIGNED <u>30 Nov 57</u>			
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>				ADDRESS <u>Easton, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/30/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>EASTON MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hampton Powell</u>				ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>11/30/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>N.A. Newkirk</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED (Print name in full)		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
DATE OF BIRTH (Month, day, year)		PLACE OF BIRTH (City, State, Country)	
OCCUPATION (If deceased was engaged in any occupation, trade, or profession, state it here)		CAUSE OF DEATH (State the cause of death in full, giving the immediate cause, and the disease or injury which caused it, and the condition which led to it, if known)	
PLACE OF DEATH (City, State, Country)		TIME OF DEATH (Hour, minute, second)	
NAME OF PHYSICIAN (If deceased was attended by a physician, state his name)		NAME OF FUNERAL HOME (If deceased was buried, state the name of the funeral home)	
NAME OF BURIAL PLACE (If deceased was buried, state the name of the burial place)		NAME OF MINISTER OF THE GOSPEL (If deceased was buried, state the name of the minister of the gospel)	
NAME OF NEXT OF KIN (If deceased was buried, state the name of the next of kin)		NAME OF WITNESS (If deceased was buried, state the name of the witness)	
NAME OF REGISTRAR (If deceased was buried, state the name of the registrar)		NAME OF CLERK (If deceased was buried, state the name of the clerk)	

RECEIVED
 DEC 10 1957
 BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12356

12351

CERTIFICATE OF DEATH

Reg. Dist. No.

290

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stenton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>510 Lincoln Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Vonderhaar</u> Middle <u>Storchia</u> Last <u>Storchia</u>				4. DATE OF DEATH Month <u>11</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>B.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 13, 1933</u>	
9. AGE (In years last birthday) <u>24</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>17</u>		IF UNDER 24 HRS. Hours <u>17</u> Min. <u>1957</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stu</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>			
11. BIRTHPLACE (State or foreign country) <u>USA.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13. FATHER'S NAME <u>Howard Brown</u>				14. MOTHER'S MAIDEN NAME <u>Rodie Pinkett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Randy Storchia (husb)</u>			
17. INFORMANT <u>Randy Storchia (husb)</u>				Address <u>219 S. Washington St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metabolic disorder</u> <u>410X</u> DUE TO <u>Rheumatic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>11/12/57</u> , 19 <u>57</u> , to <u>11/17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/17</u> , 19 <u>57</u> , and that death occurred at <u>3:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.				ADDRESS (Street, city or town, state) <u>219 S. Washington St</u> DATE SIGNED <u>19 Nov 57</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				ADDRESS <u>Easton 16, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Nov 2, 1957</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Sanctuary</u>				22d. LOCATION (City, town, or county) (State) <u>Hillsboro Ind.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. King Harrison</u>				ADDRESS <u>Stenton Ind.</u>			
24a. REC'D BY REGISTRAR <u>N. H. Newen</u>				DATE <u>11/21/57</u>			

BUREAU V. S.

NOV 22 1957

RECEIVED

12352

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN 1b 2 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bozman	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital			d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Harold Middle Hoyt Last Talley, Jr.			4. DATE OF DEATH Month November Day 29 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1950	9. AGE (In years last birthday) 7 yrs.	IF UNDER 1 YEAR Months 7 Days 7 Hours 7 Min. 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Student		10b. KIND OF BUSINESS OR INDUSTRY Public School		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Harold H. Talley		
14. MOTHER'S MAIDEN NAME F. Marie Moore			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO. None			17. INFORMANT Rev. Harold H. Talley, Bozman, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Automobile Accident DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 2 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) head-on collision			
20c. TIME OF INJURY Hour 5 a.m. 11/29 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	
20f. (City or town) Rural Federalsburg, Md		20g. (County) (State) Bozman, Maryland			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Dawson O. George		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Nov. 29, 1957	
EXAMINER'S NAME (Type) Dawson O. George, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 3, 1957		22c. NAME OF CEMETERY OR CREMATORY Manahath Cemetery	
22d. LOCATION (City, town, or county) Glassboro, New Jersey		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		ADDRESS Federalsburg, Maryland		24a. REC'D BY REGISTRAR 12/3/57	
24b. REGISTRAR'S SIGNATURE J.H. Neuman					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

DEC 10 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12353

CERTIFICATE OF DEATH

12357

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>1 207 Brookletts Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Nettie H</u> First Middle Last <u>Tarbutten</u>				4. DATE OF DEATH Month <u>November</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 26 1875</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H W</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Samuel Slaughter</u>				14. MOTHER'S M maiden name <u>Emily Addaway</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mr. Emory W Slaughter</u>				Address <u>309 S. Harrison Easton Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Coronary Disease</u> DUE TO (c) <u>Hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>?</u> <u>Several yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11/21/1957</u> to <u>11/22/1957</u> , that I last saw the deceased alive on <u>11/21/1957</u> , and that death occurred at <u>2:35 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. J. Cox</u>				ADDRESS (Street, city or town, state) <u>Easton Md.</u>			
PHYSICIAN'S NAME (Type) <u>P. F. Cox</u>				DATE SIGNED <u>11/22/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 23, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Neuman</u>				ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>11/25/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>M. E. Neuman</u>			

BUREAU V. S.

1957 68 NOV

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
Items 18&20 Film 223 11-29-57 ams										
12354 CERTIFICATE OF DEATH										
Reg. Dist. No. 290										
1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>TALBOT</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>			c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>xo St Michaels</u> ✓					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp</u>					d. STREET ADDRESS <u>1</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Trusty</u> Last <u>Trusty</u>					4. DATE OF DEATH Month <u>11</u> Day <u>15</u> Year <u>19 57</u>					
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>Wol</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 2 1882</u>		9. AGE (In years last birthday) yrs. <u>75</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>William Trusty, son - 93 Pleasantville, Md</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>904.0</u> <u>x DUE TO</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fractured rt hip</u> <u>DUE TO</u> (c) <u>Diabetes Mellitus</u> INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>10 yrs</u>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Fractured rt hip - 1 wk.</u>										
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Apparently had some episode of cerebral anoxia (angiospasm) & fell at home</u>					
20c. TIME OF INJURY Hour <u>?</u> a. m. <u>11-5-57</u> 19 <u>57</u> p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>St. Michaels Talbot Maryland</u>	
21. I certify that I attended the deceased from <u>11/10</u> , 19 <u>57</u> , to <u>11/15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/15</u> , 19 <u>57</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.										
ACTUAL SIGNATURE <u>A. Lane Wroth</u> M.D.					ADDRESS (Street, city or town, state) <u>Box 487, St. Michaels, Md</u>					
PHYSICIAN'S NAME (Type) <u>A. Lane Wroth</u>					DATE SIGNED <u>11-16-57</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)				
<u>Burial</u>		<u>Nov 18 1957</u>		<u>Charles E. Thomas Mem.</u>		<u>St. Michaels Md</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hamilton Harrison</u>					ADDRESS <u>St. Michaels Md</u>		24a. REC'D BY REGISTRAR DATE <u>11/21/57</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Nevers</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH-CAMBRIDGE 18

BUREAU V. S.

NOV 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12355

CERTIFICATE OF DEATH

Reg. Dist. No. 13641 290

1. PLACE OF DEATH o. COUNTY <u>Tollst</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Church Hill, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial</u>				d. STREET ADDRESS <u>17002</u>			
3. NAME OF DECEASED (Type or print) First <u>Dean</u> Middle <u>Werner</u> Last <u>Werner</u>				4. DATE OF DEATH Month <u>11</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/20/34</u>	
9. AGE (In years last birthday) <u>23</u> yrs.		IF UNDER 1 YEAR Months <u>29</u> Days <u>29</u> Hours <u>19</u> Min. <u>57</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Houston Shawley</u>				14. MOTHER'S MAIDEN NAME <u>Grace Murphy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>				16. SOCIAL SECURITY NO. <u>17. INFORMANT</u> <u>Mr. Robert Werner (husband)</u> Address <u>Church Hill, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>592x</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic glomerulonephritis</u> DUE TO (c) <u>?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>9</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>29 Nov</u> , 19 <u>57</u> , to <u>29 Nov</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>29 Nov</u> , 19 <u>57</u> , and that death occurred at <u>11:02 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D.				ADDRESS (Street, city or town, state) <u>Easton, Md.</u> DATE SIGNED <u>30 Nov 57</u>			
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec. 3, 1957</u>		<u>Denton</u>		<u>Denton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Virgil Thomas</u> ADDRESS <u>Denton, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>12/3/57</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Perkins</u>	

RECEIVED

DEC 10 1957

BUREAU V. S.

MAYALAN DEPARTMENT OF HEALTH - JALAPORTE 18	
CERTIFICATE OF DEATH	
1. NAME OF DECEASED	
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5. PLACE OF BIRTH	
6. OCCUPATION	
7. CAUSE OF DEATH	
8. DATE OF DEATH	
9. TIME OF DEATH	
10. PLACE OF DEATH	
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100. SIGNATURE OF WITNESS	

12366

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels		c. LENGTH OF STAY IN 1b 10 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KATHERINE Middle C. Last WRIGHTSON		4. DATE OF DEATH Month November Day 28 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1921
9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR Months 36 Days 36 Hours 36 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Philadelphia, Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Clokey		14. MOTHER'S MAIDEN NAME Edith Shoffner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Kenneth Wrightson, St. Michaels, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac failure 081X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chronic anoxia DUE TO (c) -----		INTERVAL BETWEEN ONSET, AND DEATH 1 mo 6 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) poliomyelitis - severe - chest & shoulder girdle		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) (1956 polio case)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-9 , 19 53 , to 11-28 , 19 57 , that I last saw the deceased alive on 11-28 , 19 57 , and that death occurred at 10:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Guy M. Reiser M.D.		ADDRESS (Street, city or town, state) DATE SIGNED St. Michaels, Md. 11-29-57	
PHYSICIAN'S NAME (Type) Guy M. Reiser			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov 30, 1957	22c. NAME OF CEMETERY OR CREMATORY Olivet Cemetery	22d. LOCATION (City, town, or county) (State) St. Michaels, Md.
23. FUNERAL DIRECTOR'S SIGNATURE S. Hamilton Harrison, St. Michaels, Md.		24a. REC'D BY REGISTRAR DEC 2 '57	
ADDRESS St. Michaels, Md.		24b. REGISTRAR'S SIGNATURE Alfred Smith	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

To be filled out by the physician or other qualified person who attended the deceased.

Name of deceased

Age

Sex

Place of birth

Date of birth

Place of death

Signature of physician

Signature of registrar

Date of death

Time of death

Place of death

Signature of physician

Signature of registrar

Date of death

Time of death

Place of death

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DEC 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12356

CERTIFICATE OF DEATH

Reg. Dist. No. 12360

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Yeatman</u> Last <u>Yeatman</u>				4. DATE OF DEATH Month <u>11</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>Wh.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/10/194</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Howard Dadds</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. Skinner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. William Yeatman (husb.)</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>434.3</u> DUE TO <u>Chronic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. <u>11</u> p. <u>m.</u> 19 <u>57</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Birth</u> , 19 <u> </u> , to <u> </u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-11-57</u> , and that death occurred at <u>8:25 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>				DATE SIGNED <u>219 S. Walnut St. Md.</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				<u>Eastern 16, Mary 12nd</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>11-11-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bellevue Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St. Michaels Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newman</u>				ADDRESS <u>101</u>		24a. REC'D BY REGISTRAR DATE <u>11/9/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>N. S. Neer</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12357

CERTIFICATE OF DEATH

12361
 Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Penna.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u> 75x-3 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>207 E. Wyoming Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>M.</u> Last <u>Young</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-24-1877</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Young</u>		14. MOTHER'S MAIDEN NAME <u>Ellen ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)	
17. INFORMANT <u>Mrs. Harry Massa</u>		Address <u>Philad. Penna. 1247 Orthodox St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arteriosclerotic Cardia</u> DUE TO (c) <u>Vascular Dis</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u> 5+ yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Emphysema - Small</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>23 Nov</u> , 19 <u>57</u> , to <u>23 Nov</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>23 Nov</u> , 19 <u>57</u> , and that death occurred at <u>830 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>X. Lane Wroth</u>		ADDRESS (Street, city or town, state) <u>Box 487, St. Michaels, Md 21157</u>	
PHYSICIAN'S NAME (Type) <u>X. Lane Wroth</u>		DATE SIGNED <u>11-23-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 26, 57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Philadelphia Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Keston Funeral Home</u>		24a. REC'D BY REGISTRAR DATE <u>11/26/57</u>	
24b. REGISTRAR'S SIGNATURE <u>N. H. Neeress</u>			

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NOV 29 1957

12358

CERTIFICATE OF DEATH

Reg. Dist. No. 13645 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg. 05x0.2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Donato</u> Last <u>Zaffere</u>				4. DATE OF DEATH Month <u>November</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 5, 1910</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>18</u> Hours <u>15</u> Min.		IF UNDER 24 HRS. Months <u>7</u> Days <u>18</u> Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker Owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pastry</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Anthony Zaffere</u>				14. MOTHER'S MAIDEN NAME <u>Mary Donato</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-32-0494</u>		17. INFORMANT <u>Mrs Anna Mabel Zaffere</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) <u>Coronary atherosclerosis</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. s. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>August</u> , 19 <u>57</u> , to <u>11/28/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/28/57</u> , 19 <u>57</u> , and that death occurred at <u>7:55 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>11/29/57</u>							
ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D.							
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest</u>		22d. LOCATION (City, town, or county) (State) <u>Federalburg Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frampton</u> ADDRESS <u>4210 N. Federalburg, Maryland</u>				24a. REC'D BY REGISTRAR <u>DATE 12/2/57</u>		24b. REGISTRAR'S SIGNATURE <u>M. H. Newlin</u>	

CERTIFICATE OF DEATH

Form 100-100

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. PLACE OF DEATH	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. DATE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF NEXT OF KIN		17. SIGNATURE OF CLERGYMAN		18. SIGNATURE OF MINISTER	
19. SIGNATURE OF CHURCH		20. SIGNATURE OF FUNERAL HOME		21. SIGNATURE OF BURIAL PLACE	
22. SIGNATURE OF INTERMENT		23. SIGNATURE OF CREMATION		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
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